MERCER

Consulting. Outsourcing. Investments.

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

North Carolina Department of Health and Human Services

November 2, 2010

Behavioral health Medicaid waiver expansion

Training meeting

Jane Szymanski

Jack Peters

Local managed entity (LME) training topics

- Areas to be covered for operating a Behavior Health Managed Care Organization (BH-MCO)
  - Information Technology (IT) systems
  - Staffing and training
  - System set-up
  - Provider data and system integration
  - Enrollment information
  - Authorizations
  - Claims processing
  - Claims quality audit
  - Reporting
  - Disaster and contingency planning
  - BH-MCO policy and procedures
  - Future planning
  - Next steps

IT systems for BH-MCO

What system to choose

- Waiver organization decides which system to use
- System vendor
  - Vendor relationship
  - Responsibility of system programming
    - Vendor or BH-MCO plan
- System
  - Flexibility – what customization is necessary for waiver requirements?
  - Capacity to grow with adding additional members and system users
- System updates/changes
  - Federal changes
  - Policy changes
  - Vendor software maintenance and updates/patches
  - Testing

What system to choose (cont'd)

- Required functionality (modules)
  - System set-up
    - Benefit set-up
    - Separation of funds:
      - Waiver, State and county funds
  - Provider and data
  - Eligibility and enrollment
    - Data capture
    - Maintenance of member data
    - Capitation payment

What system to choose (cont'd)

- Required functionality (modules) continued
  - Authorizations
  - Incoming claims
    - Paper
      - Imaging?
    - Electronic
      - Clearinghouse
      - Provider portal
  - Claims processing
    - Line by line or span of dates
  - Reporting
    - Internal
    - External
- System(s) integration

What system to choose (cont'd)

- HIPAA compliant
  - Receive (inbound) and send (outbound) HIPAA compliant transaction formats
    - Institutional (837I) and Professional (837P) claims/encounter data
      - Contain the national standard codes
        - Revenue codes
        - Procedure codes
        - Diagnosis codes
    - Eligibility/enrollment/capitation files
      - Eligibility and enrollment (834)
      - Capitation payment (820)
      - Eligibility inquiry and response (270/271)
    - Claim inquiry and response (276/277)
    - Authorization request and response (278)
    - Healthcare remittance advice (835)

What system to choose (cont'd)

- System security
  - HIPAA standards
    - Levels of security with separation of duties
- System accessibility
  - In-house staff
  - Are there staff that work outside of the office?
- Secure protected health information (PHI) data
  - Provide privacy for PHI
    - Need to know basis
  - Secure data internally
  - Secure data externally
  - Secure submissions of data

What system to choose (cont'd)

- Link to BH-MCO website
  - Provider directory
- Provider accessibility
  - Is there a provider portal?
    - Access eligibility
    - Submit and/or retrieve authorizations
    - Submit claims
    - Check claim status
    - Obtain reports

Staffing and training

Staffing

- Determine staffing needs
  - Business needs
  - Does current staff have technical knowledge necessary to perform the functions required of a BH-MCO?

Staffing roles and responsibilities

- Separate functions for staff
  - Provider
  - Eligibility and enrollment
  - Claims processing
  - Quality audit
  - Finance
  - Fraud and abuse
  - Clinical
  - IT

Staffing

- Determine IT staffing positions needs
  - Business analyst
  - Programming
  - Testing for development or system patches/upgrades
  - Electronic data interchange (EDI)
  - Reporting
  - Encounter submissions
  - Security officer
  - Help desk

IT responsibilities

- Manage workflow
  - Day-to-day operations
  - System maintenance
- System changes
  - Workgroup
    - IT facilitator
    - Multi-departmental
    - Prioritize work
      - Operations and system changes
    - Knowledge of changes
    - Project management
    - Testing

Training

- All BH-MCO staff
  - Document system training by department

- IT and claims training
  - Determine level of training needed for staff
  - How to train
    - Formal
      - Does employee need outside training?
      - Receive training from vendor
      - Develop training materials and schedules

    - Informal
      - Who will shadow/mentor employee?

System set-up

System set-up

- Covered benefits
  - Limit benefits to the waiver programs
  - Mechanism to handle non-covered benefits
    - Need functionality to deny claims
- Separation of funds
  - Medicaid Waiver
    - Waiver b
    - Waiver c
  - State only and block grant funds
  - County funds
  - FFS on behalf of providers

Provider data and system integration

Provider data needs

- Needs for provider data
  - Provider network management
  - Care management
  - Claims system
    - Participating providers
    - Fee schedules
  - Reporting

Provider network data

- Provider network management
  - Contracting
    - Contract renewal
    - Contract terminations
  - Credentialing
  - Demographics
    - Billing and rending data
    - Provider types and specialties
    - Provider identification
      - System ID if separate
      - National Provider ID (NPI) data
      - 1099 information
  - Fee schedules
    - Link provider to waiver contracts, separate from State-funded contracts

Provider system integration

- Care management
  - Provider data with specialty for referrals
  - Which providers can take on more members?
- Claims system
  - Participating providers
  - Fee schedules
- Customer service for providers

Provider contract loads

- Need to have dates specific for changes
  - To provider
  - Associated elements
- How do you handle provider contract loading?
  - Group providers versus individual providers
  - Billing providers versus rendering providers
  - Fee-for-service (FFS) or sub-capitated arrangement
  - What data elements are the drivers?
- How do you handle loads of fee schedules?
- How do you verify the accuracy of provider data?
  - Provider specialty relationship to the service rendered

Provider identification and reporting

- Reporting
  - State reports
    - Standard reports
    - Ad hoc reports
      - Providers in network by specialty
      - Level of care for members
  - Encounter reporting
    - State provider ID
      - Currently IPRS provider ID for LME State-funded reporting
      - Future will be for the MMIS
        - TBD on the submission
        - National Provider ID (NPI) including taxonomy and zip+4

Enrollment information

Eligibility and enrollment

- Eligibility
  - Medicaid eligible
  - Responsibility of eligibility and enrollment of members is the State's – not the providers or the BH-MCO
- Enrollment
  - Notified electronically by the State
  - Different from enrollment for LME State-funded services
    - Separate from the State-funded LME members
  - Need separate group numbers to be able to report on 1915(b)(c) Waiver members

Eligibility and enrollment

- 834 files from State
  - Daily file (future)
    - Member updates and changes
  - Monthly file
    - Full file refresh
- BH-MCO must do a reconciliation
  - Capability to send 270 and receive 271 (eligibility inquiry and response) files to verify eligibility
  - Handle retro-eligibility and retro-terminations
  - Review State system for discrepancies
  - Report any issues to the State
  - State has final word on discrepancies

Capitation payments

- HIPAA 820 capitation payment report
  - Monthly list containing each member and the rate the BH-MCO is receiving
- Reconciliation of capitation payment to the enrollment data
  - Are there issues in what payment is received to (by) the members on (in) the system?
    - Possible issues may be:
      - Change to a Waiver 1915c if the application has not yet finished processing
      - Issue with system load for the 834 file
      - Member terminated
      - Member is new

Authorizations

Authorizations

- Integration of authorizations
  - Link to provider
    - Active providers
    - Specialty of providers
    - Capacity of providers
  - Link to next period of review by care management
  - Link to claims
    - Services that are authorized that can be paid
    - Automate the number of services already paid
  - Reporting
    - Many examples of reporting:
      - Generate denial letters based on physician decision
      - Types of providers receiving authorizations and not submitting claims

Claims processing

Claims system

- Claim data elements
- Claims processing edits
- Linking claims to authorizations
- Automation or manual processing of claims
- Claims payment

Claims system data elements

- Collecting data elements from provider
  - Member
  - Provider
    - Billing and rendering
  - Type of bill (if institutional)
  - Date(s) of service
  - Diagnosis code(s)
  - Place of service
  - Procedures and appropriate modifiers
    - CPT/HCPCS or revenue codes
  - Units
  - Providers billed amount for the service
  - Other insurance information

Claims processing edits

- Processing edits
  - Eligibility
  - Provider
  - Date of service
    - Valid
    - Member eligible on date of service
    - Provider eligible on date of service
  - Duplicate check
  - Service data
    - Procedure code
    - Procedure code modifier
    - Diagnosis codes
  - Institutional formats
    - Type of bill
    - Revenue code

Claims processing and authorizations

- Linking claims to authorizations
  - Do all services need authorization?
  - Was the service authorized?
  - Is the units of service right?
  - Is the service within the dates of service authorized?
  - Can system automatically link to the authorization?
    - By authorization number?
    - By member, provider, procedure and date of service?

Claims system processing

- Manual processing of claims
  - May need for special handling and consideration
  - May be inconsistent
- Automation
  - Receive the data
    - All edits with policy applied
  - Pass through system without manual intervention
- Reason codes developed
  - Clear to understand and explain why claim not payable
  - Be able to crosswalk the system reason codes to the standard HIPAA 835 remittance advice codes

Claims processing payment determination

- Pricing the services
  - Covered benefit
  - FFS payment or part of capitation agreement
  - Lesser of logic
  - Prompt payment requirements
  - Interest due
- Fee schedules
  - What if service not in the fee schedule?
  - What if a non-network provider?
  - Does clinical staff negotiate a fee for certain services?
- Coordinating benefits with primary insurance companies including Medicare
  - Medicaid is payer of last resort

Claim adjustments

- System capabilities
  - Information for adjustments and voids must be held within the claims system
  - Have capability to perform the void or adjustment
  - Have reason codes to know why the adjustment or void occurred

Member	Provider	DOS	Procedure	Description	Payment	Description	Pay Date	Reason
Mickey	Dr. Psychiatrist	7/5/09	90801	Diag Interview	$ 100	Original payment	7/24/09	Pay per schedule
Mickey	Dr. Psychiatrist	7/5/09	90801	Diag Interview	$ -100	Void	9/6/09	Contract update
Mickey	Dr. Psychiatrist	7/5/09	90801	Diag interview	$ 120	New payment	9/6/09	Pay per schedule

Claims outcome communication

- If payment from a separate system
  - Claim system must contain
    - Date of check
    - Check number
    - Amount of check
    - Who paid
- Reporting payments or denials
  - Electronic
    - 835 explanation of payment (EOP)
    - Electronic fund transfer (EFT) payments
  - Paper EOP
  - Additional reporting to provider
    - Cannot be replacement for EOP

Claims quality audits

Quality audits

- Claims audits should be 2–3% of submitted claims
  - Audit incoming paper claims data entry
  - Audit claims processes to be sure correct
    - Paper and electronically submitted claims
- Focused audit
  - When looking for specific issues
- Test new system implementations for accuracy (end-to-end)

Reporting

Types of reporting

- Internal
  - Management operations
  - Daily operations
- External
  - Board of directors
  - State
    - Financial reporting
    - Ad hoc reporting
    - Encounter reporting

Internal reporting

- Management operations
  - Financial planning
  - Clinical operations
  - Quality management
  - Provider network
  - Contract compliance
  - Ad hoc reporting
- Daily operations
  - IT
  - Care managers
  - Claims
  - Accounting
  - Checks to providers

External financial reporting

- State or board of directors
  - Oversight of key financial and business operations functions
    - Organization internal controls
    - Business plan
    - Financial risk management plan and reports
  - Audited financial statements
    - Accounting systems/administrative expense data, general ledger
    - Cost-allocation methodology
    - Provider reimbursement
  - Track revenue and expenditures by funding stream

Other external reporting

- Ad hoc reports
- Encounter reporting
  - Currently reporting is in proprietary formats
  - Future reporting is expected to be to the State MMIS in the HIPAA formats
- Rate setting
  - Data and financial reports

System and reporting

- Standard reports
  - What reports are standard?
    - Daily
    - Weekly
    - Monthly
    - Annually
  - When are reports run?
- Ad hoc reports
  - What data is available for ad hoc reports?
  - Who can run reports?
  - When can ad hoc be run?

Disaster and contingency planning

System backups, recovery and disaster planning

- Backups
  - Daily
  - Weekly
  - Quarterly
  - Annually
- Recovery process
- Contingency planning
  - Hot spot
  - Alternate processes in place
- Testing of processes

BH-MCO
policies and procedures

Policy and Procedure purpose

- Necessary to eliminate manual processes
- Provides for consistency in processes
- Provides an audit trail of decisions made
- Establishes a baseline for measurement over time

Policy and procedures

- Manuals
  - System manuals
    - IT, claims, finance
- Specific procedures
  - Support all business aspects
  - Document as developing areas
- Annual review

Future planning

Strategic planning

- 5-year planning
  - Oversight of key financial and business operations functions
  - Business plan
  - Financial risk management plan and other management reports
  - Project planning
  - Project plans for those with budgets
- State policy changes
- Capital improvements
  - Claims system
  - Accounting system
  - Clinical
  - Provider
  - Phone system

Strategic planning (cont'd)

- System programming
  - Federal mandates
    - 5010 planning
      - Testing in 2011
      - Implementation from 4010 to 5010 on January 1, 2012
    - ICD-10 diagnosis code planning
      - Implementation on October 1, 2013
      - Maintain ICD-9 diagnosis codes received after October 1, 2013, with dates of services prior to October 1, 2013
- System integration
  - National System of Care or Health Information Technology
    - How would your system integrate with the other systems?

Questions?

Next steps

- For all of those attending today, please have one member of your organization send an e-mail to Ken Marsh at ken.marsh@dhhs.nc.gov
  - Include the attendees for this training session from your LME, including their name and department
- Follow-up two-hour conference call
  - Give LMEs opportunity to ask additional questions
  - When: January
  - Submit questions/topics for the follow-up call ahead of time to Ken Marsh
- Adjournment

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN